



Behavioral Health Impacts of COVID-19: Virginia Forecast

Tuesday, December 22, 2020

Reference:

Virginia Department of Behavioral Health and Developmental Services. Behavioral Health Impacts of COVID-19: Virginia Forecast. Published online July 23, 2020. Accessible through: www.dbhds.virginia.gov/COVID-19

Executive Summary

The unprecedented COVID-19 pandemic and the resulting health impact, uncertainty, social isolation, and economic distress are expected to substantially increase the behavioral health needs of Virginians. Though data and research specific to the impact of COVID-19 on behavioral health is still scarce, new studies as well as studies of traumatic events ranging from natural disasters to economic downturns have found that these events lead to increased behavioral health challenges, including mental health conditions and substance use disorders. A Kaiser Family Foundation (KFF) poll found that 45 percent of adults across the United States report that COVID-19 has negatively impacted their mental health, which translates to 2.9 million Virginians. A Mental Health America poll found that among youth ages 11-17 with symptoms of depression or anxiety during COVID-19, the largest concerns were loneliness and isolation and past trauma (with relationship problems, coronavirus, and grief or loss being other concerns). Behavioral and emotional impacts of COVID-19 on Virginians include:

- Traumatic stress reactions, including feelings of shock, confusion, or fear
- Social isolation and loneliness
- Grief and loss
- Hopelessness and depression
- Domestic violence and child abuse
- Alcohol and substance use

A statistical model conducted by Wellbeing Trust estimated that these challenges will result in an additional 1,720 deaths of despair, or deaths due to suicide or overdose, in Virginia alone during the recovery period of COVID-19. In addition to the wide-ranging behavioral health impacts of COVID-19, there are also specific populations in Virginians who are particularly at-risk:

- COVID-19 frontline and first responders (including law enforcement and fire/EMS workers, hospital staff, long term care staff, behavioral health and developmental disability staff, as well as grocery store workers and delivery workers)
- Those living in congregate settings, including nursing homes, state mental health hospitals, jails, and other settings
- Individuals experiencing homelessness
- Individuals who have lost loved ones to the virus
- Those in recovery from substance use disorders and serious mental illness
- Children and adults who are not safe at home (for example, family violence)

While evidence indicates the need for support and services is increasing, Virginians will be faced with a damaged behavioral healthcare system. Increased costs from personal protective equipment (PPE) and telehealth equipment, paired with reduced revenue and cancelled services during the initial months of the pandemic, have forced many behavioral health providers to furlough or layoff staff, close services, and reduce access. Community Services Boards (CSBs) have been particularly hard hit as behavioral health providers who also offer the public a behavioral health safety net for individuals who cannot access care through other pathways. Although all CSBs have continued to provide code-mandated services throughout the pandemic, and CSBs as well as private providers have quickly transitioned services to telehealth when possible, providing services safely (e.g., decreasing group size and bed capacity) has resulted in business changes with financial and access impacts.

This working paper outlines the specific behavioral health impacts we can expect from COVID-19, using validated statistical prediction and citing new research when available. It then addresses the impact of the virus on the service delivery system and, finally, identifies areas where long-term investments and strategic policy making will be needed during the COVID-19 recovery, which include:

- Ongoing prevention and outreach funding in order to address the anticipated long period of recovery expected during and following COVID-19 pandemic
- Investments in and flexibilities for the behavioral health provider network to maintain workforce and keep critical services and programs open and accessible during COVID-19 pandemic and in its aftermath
- Flexible funding for housing for individuals who are homeless or at risk
- Continued progress on behavioral health systems transformation, including STEP-VA and Behavioral Health Enhancements
- Use of a health equity framework to consider race-based health disparities in all COVID-19 behavioral health recovery initiatives

Introduction

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Model Assumptions

Given the unprecedented nature of the COVID-19 pandemic, a number of data points, research, and existing predictive models were referenced to estimate the forecasted impacts presented in this report. First, a robust scientific literature regarding the impact of traumatic events and stressors on behavioral health indicates that conclusions can be drawn across event types (i.e., research regarding the impact of other traumatic events, such as mass casualty events, traumatic loss of loved ones, or natural disasters such as hurricanes, tsunamis, or tornadoes, can inform predictions for pandemic impacts when pandemic-specific research is not available). Second, the 2008 Great Recession and associated recovery can be used to draw conclusions regarding the impact of the economic downturn, including mass unemployment, on the behavioral health, including mental health and substance use, of Virginians across the developmental span. Finally, new research regarding COVID-19 behavioral health impacts, including research from countries who faced the first wave of coronavirus months prior to the United States, although scarce, has begun to emerge.

Emotional and Behavioral Impacts

General mental health, depression and anxiety, in adults and youth: A Kaiser Family Foundation (KFF) poll indicated that 45 percent of adults in the United States reported that their mental health has been negatively impacted due to worry and stress over the virus¹. This translates to a negative mental health impact on 2.9 million adults in Virginia. Additionally, Mental Health America (MHA) reported COVID-19 mental health concerns (April 13-30, 2020) for youth (11-17 year olds) and adults (18-65+).² The table below highlights percentages of “Top 3 things contributing to your mental health problems right now” for youth and adults who screened positive for moderate or severe anxiety as well as moderate or severe depression. *Loneliness or isolation* was a key concern for youth, followed by past trauma. Loneliness or isolation was the top concern for adults with depression, whereas grief and Coronavirus anxiety were highest for adults with anxiety.

An estimated 2.9 million Virginian adults may have experienced or be experiencing a negative impact on their mental health due to worry and stress over COVID-19.

¹ KFF Coronavirus Poll: March 2020. <https://www.kff.org/global-health-policy/poll-finding/kff-coronavirus-poll-march-2020/>

² Mental Health America. Mental Health Screening Resources. Accessed July 27, 2020. <https://screening.mhanational.org/screening-tools>

Concern (Top 3)	Youth with positive anxiety screen	Youth with positive depression screen	Adults with positive anxiety screen	Adults with positive depression screen
Coronavirus	31.58%	27.26%	49.82%	34.17%
Loneliness or isolation	76.46%	81.79%	28.59%	67.35%
Grief or loss of someone or something	26.68%	26.73%	54.62%	27.93%
Past trauma	50.80%	47.98%	44.28%	46.93%
Relationship problems	39.69%	41.97%	38.11%	44.21%

DBHDS's Office of Child and Family Services, in partnership with the Virginia American Academy of Pediatrics (VA-AAP) and the Medical Society of Virginia, conducted a survey in August 2020 across the state to pediatricians, family medicine physicians, and family nurse practitioners to understand the behavioral health impacts of COVID-19 on children and adolescents in Virginia who were seeking primary care services. One hundred forty-four respondents completed the survey, and 88 percent stated they are seeing more of their patients present with mental health symptoms since COVID-19 began in March 2020 than previously. Close to 80 percent of the primary care providers (N=144) reported that since March 2020, compared to the same time last year, they are seeing anywhere from a slight to moderate increase (up to 30 percent) in mental health issues in the children and adolescents they are treating. The top presenting issues that primary care providers are seeing are increased anxiety, depression, and behavioral issues that were not present before the pandemic began, and these were the top concerns across all ages of youth. Social isolation/loneliness, parental stress related to COVID-19 (i.e., work/school balance with virtual learning, job security/unemployment), and access to child and adolescent psychiatry services ranked as the biggest areas of concern and need.

Traumatic stress reactions: Traumatic stress reactions – including feelings of shock, confusion, fear, helplessness, guilt, or any number of emotions – often follow disturbing events. COVID-19, a global pandemic, will certainly be remembered as a tragic, traumatic experience. The effects of the pandemic have been far-reaching; its magnitude has meant that each individual has been impacted in some way, whether it be fear of catching the coronavirus, dealing with the ramifications of loneliness or isolation, or increased stress regarding personal financial implications.

Alcohol and substance use: Increased stress can lead to increases in alcohol and substance use. Moreover, due to changes in routine and social distancing, additional barriers for people who use substances have been created, and those in recovery may be at increased risk of relapse. Disruptions to treatment, including in-person treatment and syringe service programs, have negatively impacted individuals with an SUD. Relatedly, bystanders to an overdose might be reluctant to perform life-saving measures, and individuals may forego seeking medical attention in an emergency department or from healthcare professionals for fear of exposure to COVID-19.

An AMA issue brief, *Reports of Increases in Opioid-Related Overdose During COVID Pandemic*, outlines recommendations to reduce harm and ensure treatment.³

Social isolation and loneliness: Preliminary surveys highlight that, in the wake of the pandemic, loneliness increased by 20 to 30 percent, and emotional distress tripled – all within the first month.⁴ People who are recovering from a substance use disorder are finding it difficult to maintain sobriety with their natural support mechanisms disrupted, leading to an increase of return to use. This may be brought on by feelings of loneliness, anxiety, and boredom that individuals are struggling with.

Grief and loss: Many are experiencing grief in the wake of the COVID-19 pandemic – many have lost friends or loved ones, and most have experienced drastic changes in their daily routines. Other types of loss include unemployment, loss or reduction in support services, and other changes in lifestyle. Events such as weddings, concerts, and travel plans have been postponed or canceled, resulting in individual and collective loss in the face of an uncertain future. Additionally, the various restrictions in place due to the pandemic leave visiting ill family members or mourning in-person with other friends and family difficult if not impossible. Individuals are also dealing with anticipatory loss, or the fear that greater loss is yet to come. Signs of grief include difficulty with focusing, feelings of anger or irritability, fatigue or low-energy, headaches, and sleeping much more or less than typical.

Domestic violence and child abuse: COVID-19 has made situations especially dire for those experiencing abuse. For example, the pandemic has created new tensions within households (loss of jobs, increased financial stress, instances of abuser refusing to let victim leave for fear of contracting the coronavirus, etc.) and created additional barriers for those seeking help (loss of social circles, increased monitoring by abuser, increased hostility from abuser, and fear of fleeing to shelter because of the spread of the coronavirus). *The New York Times* reported in May 2020 that doctors and advocates for victims are seeing signs of increased violence in the home.⁵ Reports of child abuse are down since the pandemic began, with the Virginia Department of Social Services receiving about 1,600 fewer calls than expected in March.⁶ However, this most likely means that with children in isolation at home, teachers, and other adults are not present to witness signs of abuse. *The Washington Post* reported that in Virginia, referrals from school staffers in Virginia dropped by 94 percent.⁷

³ American Medical Assn, *Reports of Increases in Opioid-Related Overdose During COVID Pandemic*, <https://www.ama-assn.org/system/files/2020-07/issue-brief-increases-in-opioid-related-overdose.pdf>

⁴ Jean Twenge, Thomas Joiner, *Mental distress among U.S. adults during the COVID-19 pandemic*, <https://psyarxiv.com/wc8ud>; see Report: *Loneliness and Anxiety During Lockdown*, <https://socialpronow.com/loneliness-corona/>

⁵ Julie Bosman, *Domestic Violence Calls Mount as Restrictions Linger: 'No One Can Leave'*, May 15, 2020, <https://www.nytimes.com/2020/05/15/us/domestic-violence-coronavirus.html>

⁶ Eric Flack, *Child abuse is likely going underreported during the coronavirus pandemic*. March 31, 2020, <https://www.wusa9.com/article/news/health/coronavirus/child-abuse-going-underreported-due-to-coronavirus-schools-being-out-maryland-dc-virginia/65-a04a5ecb-b91f-4f11-9421-56cf46972a89>

⁷ Samantha Schmidt, Hannah Natanson, *With kids stuck at home, ER doctors see more severe cases of child abuse*, April 30, 2020, <https://www.washingtonpost.com/education/2020/04/30/child-abuse-reports-coronavirus/>

Timeline of Impacts

The Institute for Health Metrics and Evaluation (IHME) at the University of Washington projects a substantial increase in COVID-19 infections in the United States throughout the fall and winter. For Virginia specifically, IHME projected daily new infections reaching 6,185, on January 1, 2021, compared to 1,244 on October 1, 2020, if current trends continue.⁸

These projections have wide margins of error. The future prevalence of COVID-19 in Virginia is difficult to predict due to a number of variables that are in flux. In particular, the number of cases will depend on policies implemented in Virginia and in neighboring states, and on compliance with existing regulations and guidelines. In particular, future decisions made by school districts could be consequential.

An analysis from Washington State Department of Health predicted the following trajectory of behavioral health impacts (specific for depression and suicide) over time: potential peak of depression and suicides in Fall/Winter 2020/21, with potential return to baseline around March, 2021.⁹ This model highlights concern around a “trauma cascade,” which is characterized by decreased ability to cope and increased traumatic stress reactions to the pandemic stressors over time if unmanageable/uncontrolled waves of COVID-19 occur. In other words, the symptoms and reactions are compounded and become *less manageable* over time, in contrast to the achievement of a “new normal” and improved coping with pandemic stress over time.

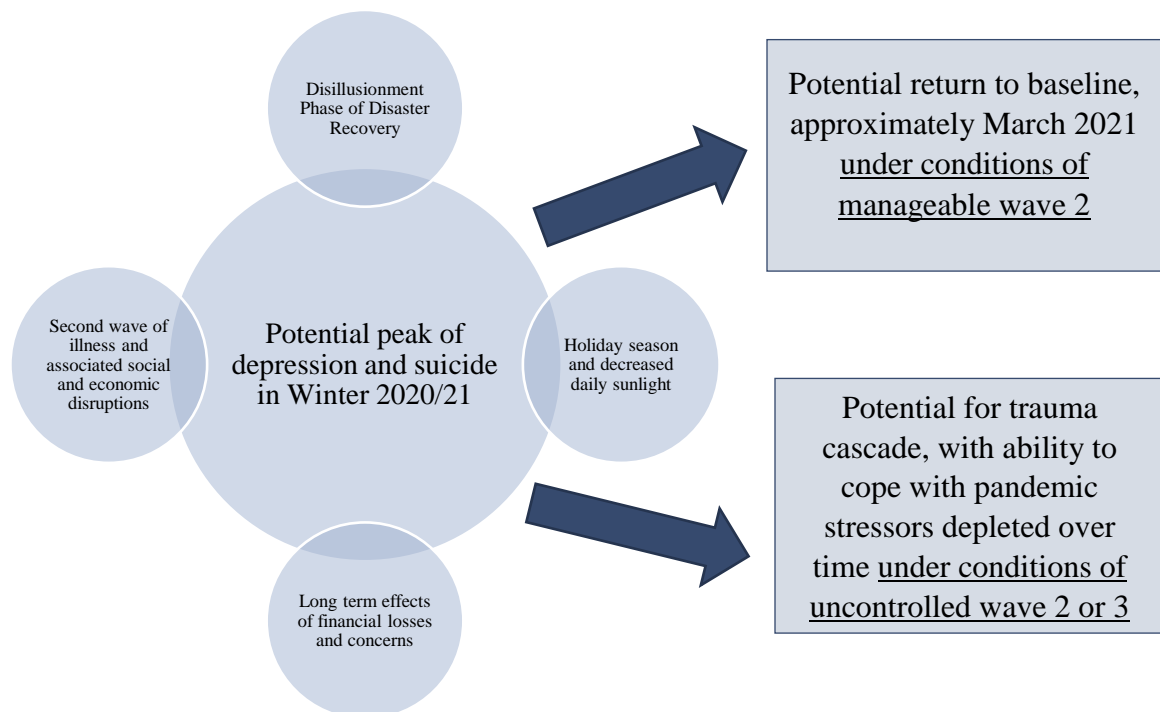


Figure 1. This heuristic provides a visual representation of a State of Washington Department of Health predictive model of behavioral health impacts over time. This model was created before additional Summer COVID-19 increases were observed in the U.S., indicating that the return to baseline in March is less likely under current conditions.

⁸ <https://covid19.healthdata.org/united-states-of-america/virginia>

⁹ Statewide High Level Analysis of Forecasted Behavioral Health Impacts of COVID-19. June, 2020.

<https://www.hca.wa.gov/assets/program/covid-19-statewide-summary-forecast-of-bh-impacts-20200624.pdf>

High-Risk Populations for Pandemic-Related Mental Health Concerns

The pandemic is emphasizing some of the weaknesses in our “support systems”, and Julianne Holt-Lunstad, professor of psychology and neuroscience and Director of the Social Connections and Health Research Laboratory at Brigham Young University, noted that “the social restrictions put in place during the pandemic may have profound long-term consequences, even after restrictions are lifted.”¹⁰ In the aftermath of Hurricane Katrina, research found both immediate and long-term adverse health and mental health consequences. Information from hurricanes and other traumatic events show that it is clear that we must take prompt and purposeful steps to assist all, and particularly high-risk populations, impacted by the COVID-19 pandemic. Consider also this excerpt from a research study surrounding the impacts of Hurricane Katrina:

*The findings also have important implications for the planning of post-disaster psychological care services. Efforts to identify and provide timely, evidence-based services to those with pre-existing psychological vulnerabilities could potentially prevent or attenuate adverse post-disaster outcomes and the progression into more serious mental illness.*¹¹

Frontline Responders: Frontline healthcare workers are prone to many risks – risk and heightened fear of contracting coronavirus (and the fear of spreading it to family members), risk of secondhand trauma, risk of experiencing PTSD, risk of experiencing burnout and fatigue, etc. Ensuring frontline workers are taken care of, both physically and mentally, must be a top priority. It is also critical to ensure care for all frontline workers, such as grocers and cleaning staff – their mental wellbeing is jeopardized as well.

Individuals living in Congregate Settings: Thousands of Virginians reside in congregate residential settings such as nursing homes, assisted living facilities, therapeutic group homes, acute psychiatric facilities, and more. These individuals are more likely to have underlying medical conditions or be of an age that puts them at higher-risk for COVID-19, and they may be in close or unsafe proximity to other residents. This risk combined with social distancing and visitation restrictions can result in high levels of stress, isolation, and loneliness, exacerbating their vulnerability to mental health conditions.

In Virginia’s behavioral health system, congregate residential settings have acutely felt the weight of COVID-19. In Virginia’s state mental health hospitals, individuals – already suffering from serious mental illness – are experiencing the stress, isolation, and loneliness detailed above. Outbreaks are also very real threats at crowded state facilities and have occurred at five of Virginia’s eight state mental health hospitals. These outbreaks, and the threat of outbreaks, puts an increased amount of stress on staff and patients that undermines a therapeutic environment. Other congregate settings, such as therapeutic group homes and psychosocial rehabilitation facilities, have reported over 70 outbreaks since the start of the pandemic. Once again, the threat of infection, the susceptibility of the residents, and the necessary social distancing for infection

¹⁰ Julianne Holt-Lunstad, *The Double Pandemic Of Social Isolation And COVID-19: Cross-Sector Policy Must Address Both*, June 22, 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20200609.53823>

¹¹ Schoenbaum M, Butler B, Kataoka S, Norquist G, Springgate B, Sullivan G, et al. Promoting mental health recovery after Hurricanes Katrina and Rita. *Archives of General Psychiatry*. 2009; 66:906–914.

control together place these residents at an increased risk of losing progress in their treatment goals, experiencing crises, and requiring higher (and more costly) levels of care.

Finally, incarcerated individuals are also especially vulnerable to COVID-19. Protecting these individuals is both a public health and human rights concern. The pandemic is spreading quickly in jails, prisons, and immigration detention centers, which provide fertile ground for the spreading of the coronavirus – crowded indoor spaces, poor ventilation and sanitization, and a lack of protective resources serve to increase the odds that an individual will contract the coronavirus. Nearly 2.3 million people are incarcerated in U.S. prisons and jails, and Virginia state responsible offenders incarcerated in DOC institutions in August 2020 was 26,135.¹²

Loss of loved ones to COVID-19: Individuals who have lost someone to COVID-19 may be particularly traumatized by the pandemic. Feelings of guilt or shame may linger. Additionally, the individual may not have been able to spend time with the suffering individual before they passed. Nor may they be able to grieve with friends and family in-person or celebrate the person's life with others due to social distancing measures. In addition to the stress, depression, and anxiety that may occur from the pandemic itself, Virginians who may not be severely impacted but know of family and loved ones who are may experience a form of survivor's guilt. This can occur when individuals feel guilty for surviving or avoiding some type of harm when others did not.¹³ They may experience feelings of irritability, anger, obsessive thoughts, and helplessness. Similarly, if they are experiencing stressors from routine changes due to COVID, they may not feel comfortable utilizing their social supports who may be experiencing significant effects from the pandemic. This lack of access can lead to increased levels of stress and guilt.

Individuals with pre-existing mental health & substance use conditions: Health service disruptions due social distancing have had detrimental impacts on various populations, including individuals with pre-existing mental health and substance use conditions and children receiving mental health services through schools. Individuals with substance user disorders (SUD) are an at-risk population due to multiple factors including to their clinical, psychological, and psychosocial conditions. Moreover, social and economic changes caused by the pandemic, along with the traditional difficulties regarding treatment access and adherence—will certainly worsen during this period, therefore aggravate their condition.¹⁴

People Experiencing Unsheltered Homeless: Individuals with behavioral health disorders are dramatically over-represented among people experiencing homelessness in Virginia. Housing is widely recognized as a social determinant of health. COVID-19 has elevated the importance of having a safe place to call home, but the potential economic impact of the pandemic also jeopardizes the safety net that the housing market provides. Housing instability and behavioral health have a bi-directional relationship: housing instability can worsen behavioral health conditions and behavioral health dysregulation can de-stabilize living situations. This is especially true among the sub-population of people experiencing homelessness who are

¹² Flattening the Curve for Incarcerated Populations – Covid-19 in Jails and Prisons. NEJM. May 28, 2020. <https://www.nejm.org/doi/full/10.1056/NEJMp2005687> & Monthly Population Summary. Virginia Department of Corrections. August 2020. <https://vadoc.virginia.gov/media/1584/vadoc-monthly-offender-population-report-2020-08.pdf>

¹³ Cherry K. Understanding survivor's guilt. (2019). Accessed July 14, 2020. <https://www.verywellmind.com/survivors-guilt-4688743>

¹⁴ The COVID-19 pandemic and its impact on substance use: Implications for prevention and treatment. Psychiatry Res. July 2020. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7219362/>

unsheltered; that is, people sleeping in places not met for human habitation. People experiencing unsheltered homelessness are more vulnerable to COVID-19 for a number of reasons, including lack of access to sanitation facilities and PPE, inability to quarantine, prevalence of other, co-morbid health conditions such as diabetes or heart disease, disproportionate representation of people of color, and relatively older age. Access to housing and services, specifically permanent supportive housing, is the solution to addressing COVID-19 vulnerability of people experiencing unsheltered homelessness.

Children & Youth, including youth-serving systems: Children may be especially affected by the pandemic as they are still developing and processing changes at the same time. They may display behaviors such as clinginess, anger, agitation, and withdrawal. Going through experiences such as this can adversely affect their mental outlook now and into adulthood.¹⁵ Reassuring youth and helping them keep regular routines during this time is vital mitigate negative outcomes.¹⁶

In May 2020, Voices for Virginia's Children along with other family-focused organizations conducted a survey to understand the economic and childcare strain families and caregivers face during the pandemic. Results from over 800 families (English and Spanish speaking) highlighted their concern about the safety of their children and balance in their lives (63 percent reported it as a top concern, 86 percent reported it as a top 3 concern). Many families were unsure about returning children to childcare as restrictions are lifted. More than 40 percent of respondents reported looking to government officials for additional guidance on areas of health and safety.¹⁷ Relatedly, uncertainty regarding returning to school, or continuing education in a virtual environment, has many parents and educators concerned.

Before COVID-19 placed an immense strain on families, 15-24 year olds accounted for 23 percent of self-harm hospitalizations in 2018 in Virginia. The CDC outlines that "adolescents may experience grief in ways that are both similar to and different than children and adults. Adolescents may experience significant changes in their sleep patterns, isolate themselves more, frequently appear irritable or frustrated, withdraw from usual activities, or engage more frequently with technology." There are also emerging trends showing disparities in suicide deaths among youth (the number of suicide deaths increased by 37 percent from 2014-2018).

Researchers from Arizona State University surveyed roughly 1,500 undergraduate students; thirteen percent of the students who responded have delayed their graduation. Roughly 40 percent had lost a job, internship, or job offer, and slightly less than one-third reported expecting to earn less at age 35 than they previously anticipated.¹⁸ The anticipated economic impacts among young adults can have lasting effects on their mental health and wellbeing.

Veterans: Prior to COVID, Veterans were at higher risk of suicide than civilians. In 2018, National data from the Veterans Health Administration showed the rate of suicide was 2.2 times

¹⁵ Gleason MM. Coronavirus pandemic: how can we reduce long-term impact on children's mental health? (2020). Accessed July 16, 2020. <https://www.chkd.org/Blog/Coronavirus-Pandemic--How-Can-We-Reduce-Long-Term-Impact-on-Children-s-Mental-Health-/>

¹⁶ The University of Vermont Health Network. Staying healthy: Learn how to stay healthy and cope with COVID-19. (2020). Accessed July 14, 2020. <https://www.uvmhealth.org/Pages/Coronavirus/Staying-Healthy/Child-Stress-During-Pandemic.aspx>

¹⁷ Voices for Virginia's Children, Virginia PTAs and Families Forward Virginia. Survey results of parents and caregivers: May 12-17, 2020. (2020). Accessed July 13, 2020. https://vakids.org/wp-content/uploads/2020/06/Parents-Caregivers-Survey-Report_FINAL.pdf

¹⁸ Madeline St. Amour, *Report: COVID-19 Has Hurt College Students*, June 23, 2020, <https://insidehighered.com/quicktakes/2020/06/23/report-covid-19-has-hurt-college-students>

higher among female veterans compared to non-veteran adult women and 1.3 times higher among male veterans compared to non-veteran adult men. Virginia is home to large numbers of military personnel – approximately 130,000 active duty members (or the second largest population in the U.S.), over 8,000 National Guard Service Members, and approximately 720,000 veterans. Specialized outreach and support to military-connected individuals in community settings will be critical to promoting wellness.

Race and Ethnicity-Based Health Disparities

COVID-19 has disproportionately impacted members of minority communities. Due to systemic racism and social inequities, members of racial and ethnic minority groups are more likely to contract and die from the coronavirus. The CDC shares:

Among some racial and ethnic minority groups, including non-Hispanic black persons, Hispanics and Latinos, and American Indians/Alaska Natives, evidence points to higher rates of hospitalization or death from COVID-19 than among non-Hispanic white persons. As of June 12, 2020, age-adjusted hospitalization rates are highest among non-Hispanic American Indian or Alaska Native and non-Hispanic black persons, followed by Hispanic or Latino persons.¹⁹

Dr. Sherita Hill Golden, Chief Diversity Officer at Johns Hopkins Medicine, outlines various conditions that contribute to these detrimental outcomes, including “living in crowded housing conditions, working in essential fields, inconsistent access to health care, chronic health conditions, and higher levels of stress.”²⁰

Additionally, PBS News shares that “there are indications that some Native American populations are facing a disproportionate brunt of the COVID-19 epidemic with higher infection and mortality rates than the overall U.S. population. Specific measures that address water infrastructure in some reservations and language or communication barriers may be warranted.”²¹ Undocumented individuals are also facing perilous results in the wake of COVID-19. For example, many undocumented workers fear attempting to seek COVID testing or medical care. Others who work in the service or hospitality industry have lost their livelihoods. The CDC also notes that, historically, severe illness and death rates are higher for racial and ethnic minority populations during public health emergencies. Inequities in public funding and response strategies contribute to excess disease burden. Data collection, analysis, and reporting is crucial to highlight the various policy and social changes needed to address both historic and current disparities. Collaboration among sectors is needed to share information and dismantle various economic and social barriers to care.

Risk of Increased Deaths of Despair

Deaths of despair refer to suicide, overdose deaths, and deaths secondary to alcohol use. Given the health disparities just described, it is not surprising that emerging trends show disparities in

¹⁹ COVID-19 in Racial and Ethnic Minority Groups, Centers for Disease Control & prevention (CDC), updated June 25, 2020, <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>.

²⁰ Sherita Hill Golden, M.D., M.H.S., *Coronavirus in African Americans and Other People of Color*, <https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/covid19-racial-disparities>

²¹ PBS News, *How COVID-19 is impacting indigenous peoples in the U.S.*, May 13, 2020, <https://www.pbs.org/newshour/nation/how-covid-19-is-impacting-indigenous-peoples-in-the-u-s>

suicide deaths among Black or African Americans (number of suicide deaths increased 62 percent from 2014-2018). The Robert Graham Center and Wellbeing Trust modeled national and statewide projections of increases in deaths of despair due to COVID-19.²² Here, we summarize their projections with a focus on Virginia. Overall, research indicates that a 1 percent increase in unemployment increases suicide rates by 1-1.3 percent (in the United States, estimates from the Great Recession are higher at 1.6 percent).²³ The link between overdose deaths, alcohol-related deaths, and unemployment is less straightforward, with recent research estimating a 3.3 percent increase in drug-related deaths for a 1 point increase in unemployment.²⁴ There is evidence that alcohol use increases when individuals are unemployed. During times of broader economic downturn, trends in research suggest that low and moderate drinkers increase their alcohol consumption, particularly demonstrating increased binge drinking, whereas heavy drinkers' overall consumption decreases.²⁵

The Wellbeing Trust model assumes a peak unemployment rate of 15 percent in Q3 2020 and estimates the number of additional deaths in scenarios where a one point increase in unemployment led to either a 1 percent, 1.3 percent, or 1.6 percent increase in deaths of despair. The results are mapped out longitudinally under conditions of a slow, medium (the same as during the Great Recession), or fast economic recovery. Under the middle condition (1.3 percent increase and medium recovery), it is expected that Virginia will experience an additional 1,720 deaths between 2020-2029, above and beyond the predictions based on current levels. Current predictions reflect 2018 numbers: 3,715 deaths of despair per year. These estimates signal that the economic impact of COVID-19 alone could result in a 54 percent increase in deaths of despair.

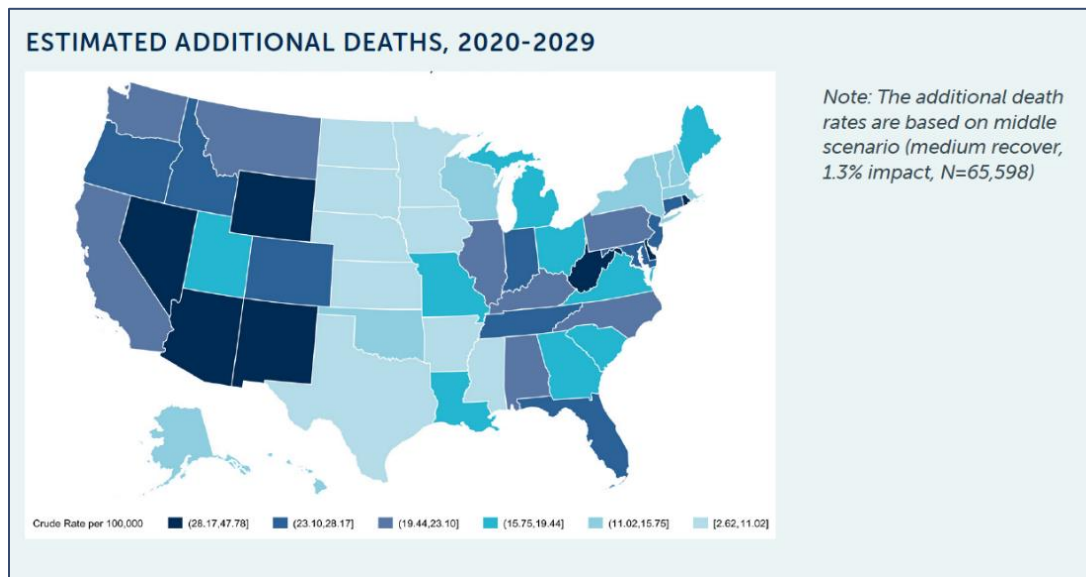


Figure 2. National projected additional deaths of despair (Source: Wellbeing Trust, 2020).

²² Patterson, Westfall, and Miller. (2020) Wellbeing Trust. https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair_COVID-19-FINAL-FINAL.pdf

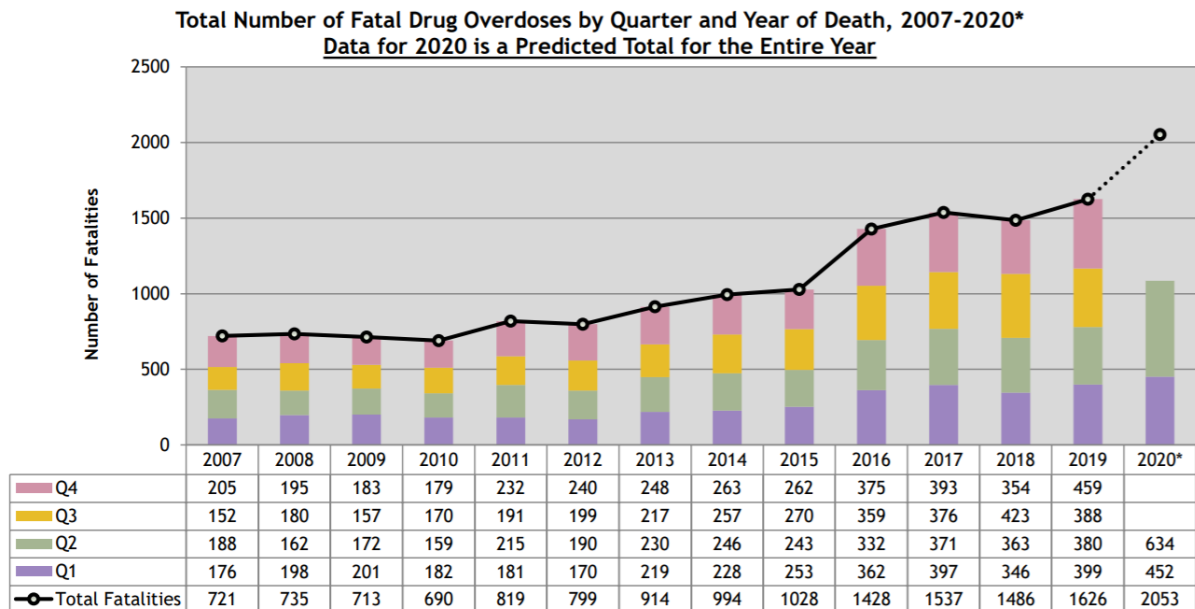
²³ Phillips and Nugent. (2014). "Suicide and the Great Recession of 2007-2009: The Role of Economic Factors in the 50 U.S. States."

²⁴ Hollingsworth, Ruhm, and Simon. (2017). "Macroeconomic Conditions and Opioid Abuse." Working Paper 23192. National Bureau of Economic Research.

²⁵ Bor, Basu, Coutts, McKee, and Stuckler (2013). Alcohol Use During the Great Recession of 2008–2009, *Alcohol and Alcoholism*, Volume 48, Issue 3, Pages 343–348, <https://doi.org/10.1093/alcalc/agt002>

There are a number of reasons to worry that the actual number of deaths of despair could be even greater than what is projected. It is important to note that drug overdoses in general have increased consistently each year over the last decade, and that the Great Recession did not occur in the context of the opioid epidemic. This raises a number of concerns, namely, that using Great Recession numbers may be an optimistic estimate. If the current trajectory of the virus continues, the assumption that unemployment will peak in Q3 2020 may be optimistic. Additionally, the expectation that the recovery will be similar the one following the Great Recession, or even faster, may also be optimistic since entire categories of businesses (those that bring people together indoors) will face ongoing challenges without a reliable, universal vaccine. Finally, the nature of the global pandemic may result in even more deaths of despair than we would typically see during an economic recession. Individuals who lose their jobs are unable to cope by spending time with family and friends, or by engaging in other meaningful activities. Isolation, fear of getting sick, and coping with the loss of loved ones may compound the expected stress of unemployment.

The Virginia Department of Health's Office of the Chief Medical Examiner publishes fatal overdose rates on a quarterly basis. The October 2020 report indicated significant increases, particularly during Quarter 2, in fatal overdoses associated with cocaine, fentanyl, methamphetamines, and in aggregate, all opioids (66.8% jump comparing Q2 2020 to Q2 2019).²⁶ In 2013, fatal drug overdoses surpassed motor vehicle-related fatalities and gun-related fatalities. Following a staggering 38.9 percent jump from 2015-2016, annual deaths have remained high. The graph below shows data from Q1 and Q2 with projections for Q3 and Q4, which would make 2020 the worst year on record for Virginia.



Additionally, first quarter non-fatal overdose indicates a statewide increase of 11 percent from the fourth quarter of 2019.²⁷ The highest increases were observed in Northern Virginia (32

²⁶ Office of the Chief Medical Examiner, Fatal Drug Overdose Quarterly Report. October 2020.

<https://www.vdh.virginia.gov/content/uploads/sites/18/2020/10/Quarterly-Drug-Death-Report-FINAL-Q2-2020.pdf>

²⁷ Emergency Department Visits for Unintentional Drug Overdose for Virginia Residents: <https://www.vdh.virginia.gov/surveillance-and-investigation/syndromic-surveillance/drug-overdose-surveillance/>

percent increase) and Southwest Virginia (11 percent increase), followed by Northwest Virginia (9 percent), Eastern Virginia (increase 6 percent), and Central Virginia (4 percent; considered “no change”). Visuals of quarterly and regional differences from the VDH report are provided here:

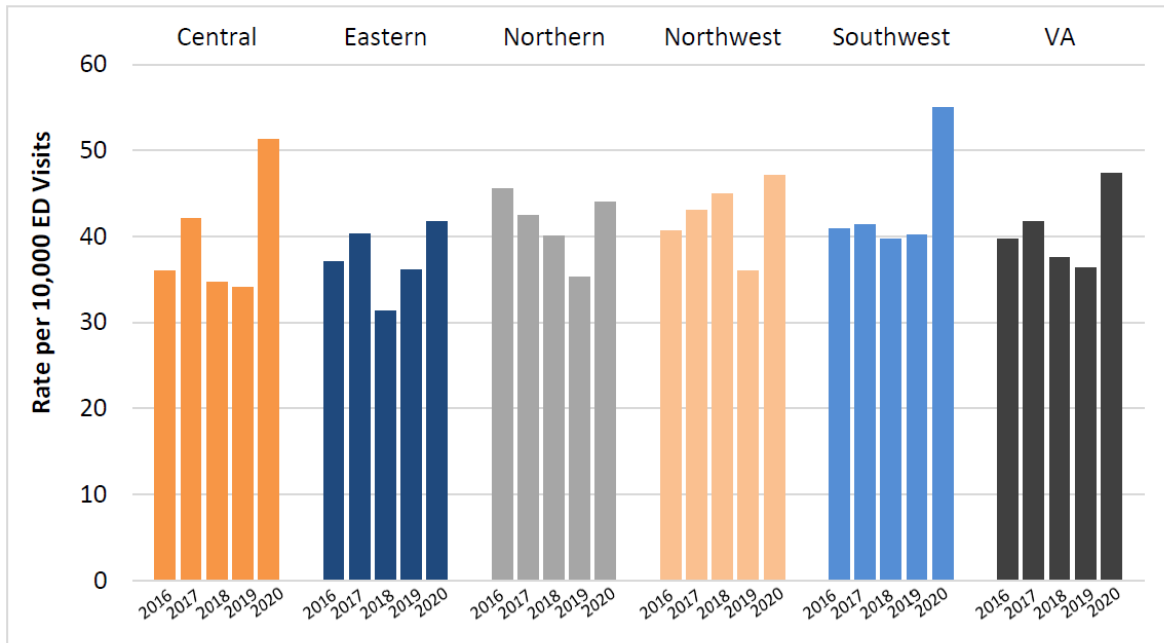


Figure 3. Year to date rate (January to March) for all drug overdose ED visits. Source: VA Department of Health.

In summary, there is robust evidence that behavioral health problems, including mental health and substance use, have increased and will increase further during and following the COVID-19 pandemic and associated social and economic stressors. Although many with behavioral health difficulties do not seek treatment, or seek treatment only once symptoms reach a crisis level, the availability and accessibility of behavioral health services in the community to anyone who needs them regardless of ability to pay is key to Virginia’s COVID-19 response and recovery. Unfortunately, the COVID-19 pandemic has caused a number of logistical, safety-related, financial, and staffing-related stressors on the behavioral health system of Virginia. This is being reported across the country, as well.

Behavioral Health Service Impacts

Despite the challenges the pandemic has introduced into the behavioral health system, Virginia providers have remained committed to providing ongoing care safely and effectively. Here, we note two key strengths and three key challenges that have been observed in Virginia as the pandemic has unfolded and actions to shutdown the spread of infection have taken hold:

Key Strength #1: quick transition to telehealth

More than 8 out of 10 CSBs transitioned to telehealth within two weeks of the state of emergency, and all transitioned to telehealth within three weeks. Private providers have undergone similar transitions. Increased telehealth flexibility has allowed providers to replace the vast majority of face-to-face encounters with telehealth including audio-visual and telephone-

only communications. Federal flexibilities for the Medicare and Medicaid programs as well as Virginia Medicaid policy now consider a patient's home to be an originating site and permit patients and providers to connect via various audio-visual technologies and even via landline phones to ensure access even in areas where broadband connections are limited. Many providers cite greater patient satisfaction with the new telehealth flexibility including reduced travel time and the ability to access services at home in a quiet, safe space. Additionally, many providers experience fewer no-shows on telehealth visits than face-to-face visits. Still, concerns exist around leveraging HIPAA-compliant technology and the costs of those technologies, offering space to individuals who may not have quiet or privacy in their homes, and offering services such as group services that are better suited in face-to-face settings.

Key Strength #2: continuity of core operations

The rapid transition to telehealth services have allowed Virginians to continue accessing care despite the threat of the pandemic and have allowed providers to continue billing for these services to support ongoing operations. During the state of emergency, DMAS has allowed many services to be billed at the same rate, regardless of whether the visit is conducted face-to-face, via HIPAA-compliant telehealth technology, or over the phone. This has helped many providers weather the storm by avoiding staff layoffs and program closures. All CSBs have continued to provide code mandated services through the COVID-19 pandemic. In addition, the Virginia Mental Health Access Program (VMAP) continues to provide pediatric-focused consultation, training, and referrals to increase primary care provider access to child and adolescent psychiatrists during the pandemic.

Key Challenge #1: Virus exposure, particularly in congregate care

While telehealth has been hugely valuable for many providers, in some instances face-to-face services cannot be avoided. This includes inpatient psychiatric services as well as group homes and other residential facilities. Providers of these services have had to quickly implement infection control policies per CDC and VDH guidance including limiting visitation, screening staff, quarantining individuals who may have been in contact with someone with COVID-19, and isolating those individuals with confirmed or suspected cases of COVID-19. We still saw a number of infections, including outbreaks at five of Virginia's eight state mental health hospitals and over 70 outbreaks in DBHDS-licensed residential settings.

Key Challenge #2: Difficulty accessing personal protective equipment (PPE)

Exacerbating the challenges associated with infection control in congregate settings is the ongoing challenge of obtaining PPE. This includes respirators, goggles, gloves, isolation gowns, and hand sanitizers. Congregate settings found these items particularly difficult to obtain earlier in the pandemic when supplies were being prioritized for medical settings.

Key Challenge #3: Increased costs, decreased revenue

For the vast majority of behavioral health providers, sustainability is a critical concern. The pandemic has increased costs for providers, increased non-billable contacts (including informal check-ins, assistance with benefits navigation, assistance with telehealth, and other pandemic-related communications).

Anecdotal reports indicate that billable contacts have declined due to canceled group visits, client cancellations because of lack of childcare, school closures limiting school-based services from continuing, etc. Ultimately, while costs have increased, reimbursement has declined, straining an already stretched safety-net system.



Operating costs have increased (including telehealth equipment, personal protective equipment, and additional cleaning supplies)

Non-billable client contacts have also increased (including brief check-ins, telehealth navigation and support, and assistance with benefits navigation)

Billable contacts have decreased, including no-show rates, inability to attend due to childcare or other quarantine demands, cancellation of group therapy that cannot be conducted under social distancing, lack of access to telehealth for some clients, and school-based service decreases due to school closures

Overall revenue has decreased, as compared to pre-COVID-19 months and year-to-year comparison for March and April (May data forthcoming)

Recommendations: How Do We Prepare for Increasing Mental Health Needs?

To help prevent permanent disruption of Virginia's behavioral health system and meet the ongoing and new, COVID-19 specific behavioral health needs of Virginians, we recommend policy officials consider the following:

Recommendation #1: The Commonwealth should explore designating state general funds for ongoing prevention and outreach funding in order to address the anticipated long period of recovery expected during and following COVID-19 pandemic

Elevating the safety net's ability to reach individuals in need of key services will be critical for months, even years, beyond the state of the emergency. This includes high impact models such as –

- ✓ ACES-informed communities: developing solution-focused plans to help families, children, and communities cultivate the resiliency to tackle traumatic childhood experiences – improving their physical, behavioral and emotional wellbeing.
- ✓ Community Coalitions: mobilizing local stakeholders to buffer the impact of risk factors for substance use disorders, mental illness and suicide through strategies specific to local need.

Virginia currently does not provide state general funds to support prevention activities in the Commonwealth. Currently programs are operating robust evidence-informed models with community/local and federal funding. As community needs grow in the wake of the pandemic and recovery, local communities that can respond to their own citizen's needs will be integral to ensuring a long-term sustained recovery.

Recommendation #2: Policy officials should examine direct investments and flexibilities for the behavioral health provider network to maintain workforce and keep critical services and programs open and accessible during COVID-19 pandemic and in its aftermath

COVID-19 has placed a significant burden on the ability of behavioral health providers to continue to operate. CDC and Virginia Department of Health guidelines, that are critical to maintaining safety of individuals and employees, have limited behavioral health provider revenues and/or increased costs for telehealth implementation, PPE, and other needs. As the Commonwealth reopens, these costs and lost revenue will continue while needs for mental health and substance use disorder treatment is anticipated to grow. The Commonwealth must consider methods to minimize disruption to the behavioral health services system. These methods will require a multi-faceted approach that incorporates:

- ✓ Sustainable investments in telehealth infrastructure including cell service and internet connection for consumers as well as secure equipment for providers. The continued availability of telehealth will be necessary to maintain access to care and supportive services as individuals balance health needs and access to care, work and childcare responsibilities, homeschool and/or alternative school schedules and transportation needs, and more.
- ✓ Payment arrangements to ensure that providers in the public behavioral health system (including CSBs and all providers who accept public insurance) are able to continue operations and afford PPE to continue to provide services
- ✓ Payment arrangements to ensure that providers who must operate at reduced revenue to maintain social distancing and proper infection control guidelines are able to continue to operate and be in a financial position to ramp up services as community infection declines and Virginia shifts to post-pandemic operations in the future.
- ✓ Increased flexibility in funding for providers to be able to respond to local needs where possible. This flexibility is critical as community infection rates vary across Virginia and different stages of re-opening take hold.

Recommendation #3: Flexible funding for housing for individuals who are homeless or at risk

Promoting shelter for individuals experiencing homelessness is fundamental not only to preventing the spread of COVID-19, but to prevent disruption in care and reduce the risk of behavioral health crises.

- ✓ Consider flexibility in existing housing resources, including financial support and community services. These are critical to stabilizing both behavioral health conditions and housing arrangements. Such areas include consideration of flexibility in Discharge Assistance Planning (DAP) funding and other housing resources.
- ✓ Permanent supportive housing (PSH) is an evidence-based solution already in use in Virginia designed to meet the needs of individuals with behavioral health disorders who are experiencing homelessness or ready to leave institutions such as state psychiatric hospitals. Continued investment in PSH permits individuals to safely quarantine at home if necessary, access treatment in the most integrated setting, and improve behavioral health outcomes.

Recommendation #4: Continued progress on behavioral health systems transformation, including STEP-VA and Behavioral Health Enhancement

Strengthening the behavioral health services continuum will help to bolster Virginia's system to respond to COVID-19 related behavioral health needs.

- ✓ Virginia is in the process of developing a robust, easily accessible crisis hotline and statewide or regional mobile crisis system, which is a key aspect of providing needed supports to individuals experiencing behavioral health crises who would otherwise be at risk of an emergency room visit, encounter with police, incarceration, or hospitalization. This includes specialized crisis services for children and youth to provide family-based services that support families to remain safely in the community, given the family-based stressors of COVID-19.
- ✓ STEP-VA, Virginia's behavioral health transformation initiative, has already led to the implementation of Same Day Access and Primary Care Screening at each of Virginia's 40 CSBs. Work remains to be done to implement Outpatient Services, Crisis Services, Veterans' Services, Peer and Family Support Services, Case Management, Psychosocial Rehabilitation, and Care Coordination across the Commonwealth. COVID-19 exacerbates the need for STEP-VA's work to increase access to treatment and support services.
- ✓ Six priority services being developed under Behavioral Health Enhancement – an initiative to develop Medicaid rates for evidenced-based behavioral health services – include Assertive Community Treatment (ACT), Multisystemic Therapy (MST) and Functional Family Therapy (FFT), Comprehensive Crisis Services (to provide Medicaid rates consistent with STEP-VA crisis system), and Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP). These services, when enhanced under the Medicaid benefit, will provide community-based supports for individuals at risk of behavioral health crisis, hospitalization, and criminal justice involvement. Leveraging the federal match afforded by Medicaid enhancements provides critical funding for the public behavioral health system.

Recommendation #5: Apply a health equity framework and consider race-based health disparities in all COVID-19 behavioral health recovery initiatives

Race-based disparities in access to health care, including behavioral healthcare, are already well-documented. The unprecedented economic, social, and political anxiety that minority communities are facing is compounded by the loss of life and illness of family members and friends.

- ✓ The Commonwealth should consider that behavioral health interventions and initiatives should be designed and implemented with access and cultural considerations for communities most impacted by COVID-19.
- ✓ The behavioral health (including social and emotional needs) of underserved children and families should be prioritized alongside other concerns in the drafting of plans and policy regarding school, childcare, and other family services. This priority links closely with Recommendation #1 and a focus on prevention and outreach.
- ✓ Reporting should be required regarding access (e.g., by race, ethnicity, location) to behavioral health care for populations and communities during and after the COVID-19

pandemic to ensure that all Virginians have equitable access to care. Appropriate reporting and monitoring will help the Commonwealth identify where racial, ethnic, income, or geographic disparities exist and ensure resources are directed to address these disparities.

Conclusion

The unprecedented COVID-19 pandemic and the ensuing social isolation combined with high economic uncertainty has put millions of Virginians at increased risk of mental health challenges and substance use disorders. Simultaneously, Virginia's CSBs and private behavioral health providers have been forced to quickly adapt services to telehealth and telephone, provide safe environments and infection control for in-person and residential services including obtaining sufficient PPE, while maintaining access for the patients they serve. This has come at a cost for Virginia's behavioral health system, which is feeling the strain of the pandemic with increased costs and decreased revenue. A focus on prevention and outreach, workforce, housing, continued progress on STEP-VA and Behavioral Health Enhancement, and health equity can help address new and unmet needs across the Commonwealth.

The following DBHDS offices contributed to this report: Division of Community Services, Office of Behavioral Health Wellness, Office of Recovery Services, Office of Child and Family Services, Office of Adult Community Behavioral Health, Military and Veterans' Affairs, Office of Data Quality and Visualization, Office of Policy and Legislative Affairs